State DELAWARE

State Method on Cost Effectiveness of Employer-Based Group Health Plans

The Delaware Medicaid Program intends to review every Medicaid applicant or recipient who is eligible for enrollment in an employer-based group health plan [as defined in accordance with Section 1906(e)(1) of the Social Security Act and §5000(b)(1) of the Internal Revenue Code of 1986]. The review will target cost effectiveness. An individual's enrollment in a group health plan will be determined to be cost effective if all costs associated with the group health plan (premiums, deductibles, co-insurance, other cost sharing obligations, and administrative costs as allowed by Section 3910.11 of the State Medicaid Manual as reviesed 04/91) is less than the Medicaid payment for a set of services equivalent to those covered by the specific group plan.

Delaware's cost effectiveness variables include, but are not limited to

1) Cost of premium
2) Amount of deductible and co-insurance
3) Covered services
4) Age and sex of case members
5) Family size
6) Category of assistance

The above information is gathered and evaluated in the following manner:

1. Health Insurance Policy Information - Will be gathered at intake and redetermination intervals from information on the group health plan(s) available to the recipient. The needed information will included the effective date of the policy, benefits and exclusions of the plan, premium amounts, and general rates of payment, deductibles, and co-pay amounts.

2. Recipient Information - Staff will obtain information on each recipient on the case, including, but not limited to: age, sex, county, and aid category.

3. Average Medicaid Costs - For cases in which a claims payment history is established for the recipient, the average Medicaid cost will be determined based on the most recent year's expenditures. For cases in which an actual claims payment history is unavailable, MMIS data will be used to create an annual profile of estimated yearly costs for persons similar to the recipient based on age, sex, county and aid category.

4. Medicaid Costs for Included Services - Medicaid will determine what percentage of Medicaid expenditures would be covered under the group health plan based on the covered services of the plan. This will be done by assigning percentages to the dollars spent by Medicaid on the following services (taken from the MMIS file):
   - Inpatient Hospital
   - Outpatient Hospital (including ER)
   - Physician Medical Services (including office visits)
   - Physician Surgical Services
   - Lab & X-ray
   - Prescription Drugs
   - Maternity Care (including labor and delivery)

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When the plan is evaluated against the above services, it will be assigned a percentage to reflect the services covered under the plan (versus what Medicaid would cover- which would be 100%). The percentage of services covered by the plan will them be multiplied by the average Medicaid costs from step 3.

5. Group Health Plan Allowable - Generally, employer plans have higher allowables for services than the Medicaid Program. To determine the amount employer-based group health plans will allow for the covered services identified in step 4, multiply the amount from step 4 by a chosen factor. This factor will be either a state specific factor, a national factor, or a group health plan specific factor.

6. Covered Expense Amount - To determine the covered expense amount (allowed amount minus coinsurance and deductibles) under the group health plan, we take the allowable amount from the above step and multiply it by an average group health plan payment rate. The group health plan payment rate will be based on a state specific factor, a national factor, or a group health plan specific factor.

7. Administrative Costs - Administrative costs shall include, but not be limited to, the contractual costs of changes to the MMIS and to the Delaware Client Information System (DCIS) to allow for inclusion of non-recipients, tracking, making payments to and contracting with employers or insurance companies, etc., contractors needed to absorb the workload of current staff that will have to be diverted to this project and/or contractors required to develop, test and implement a PC-based system that will function in place of a DCIS/MMIS interface and tracking system, with the additional costs of hardware and software to support those systems and any additional staff needed. Administrative costs shall be reviewed annually and divided by the estimated potential number of Medicaid eligibles with employer-based group health insurance available.

8. Cost Effectiveness Determination - The final step will be determining if the group health plan is cost effective. A plan will be found to be cost effective if the total of the 3 following elements is less than the average Medicaid costs for the family:
   a) the difference between the group health plan allowable (step 5) and the covered expense (step 6)
   b) yearly premium
   c) administrative costs

If a group health plan is found to be cost effective, the clients/families will be advised of their obligation to enroll in that plan as a condition of initial or continued Medicaid eligibility. Failure to enroll in cost effective employer-based group health insurance shall not affect the Medicaid eligibility of any applicant/recipient who has no control over the enrollment process. The minimum enrollment period in a cost-effective group health plan will be 6 months for Delaware.